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Workplace violence prevention for nurses on-line course: Program development[1]

Daniel Hartley[a,*], **Marilyn Ridenour**[a], **John Craine**[b], and **Allison Morrill**[b]

[a]Division of Safety Research, National Institute for Occupational Safety and Health, Morgantown, WV, USA

[b]Vida Health Communications, Inc., Westwood, MA, USA

Abstract

BACKGROUND—Many entry-level and experienced healthcare professionals have not received training in workplace violence prevention strategies.

OBJECTIVE—This paper describes the development, content, and initial qualitative evaluation of an on-line course designed to give healthcare workers an opportunity to acquire free workplace violence prevention training while earning free continuing education units.

METHODS—A group of healthcare violence prevention researchers worked via email and face-to-face meetings to decide appropriate content for the course. Educational strategies used in the course include: text; video re-enactments of real-life workplace violence incidents; and videos of nurses discussing incidents of violence. Initial evaluation involved a focus group of nurses to discuss the course content and navigation.

RESULTS—The on-line course has thirteen units that take approximately 15 minutes each to complete. The focus group participants liked the “resume-where-you-left-off” technology that enables the user to complete any portion of the course, leave to do something, and return to the course where they left off. Participants viewed the “Nurses’ Voices” videos as relevant illustrations of violence that nurses face in their workplaces.

CONCLUSIONS—The focus group participants considered the course to be an effective learning tool for people new to the profession and for those with seniority.

Keywords

Workplace violence; healthcare; on-line; training

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[*]Corresponding author: Daniel Hartley, NIOSH Division of Safety Research, 1095 Willowdale Road, MS1811, Morgantown, WV 26505, USA. Tel.: +1 304 285 5812; Fax: +1 304 285 6235; dhartley@cdc.gov.

1. Introduction

The Healthcare and Social Assistance (HCSA) sector employed an estimated 18.9 million (13.6% of the total workforce) workers in 2010, making it the largest industry sector in the United States that year [1]. That same year, the HCSA sector accounted for a disproportionate number of nonfatal workplace violence injuries involving days away from work, with over 11,370 injuries (or just over 67% of nonfatal violent injuries occurring in all industries) [2]. On average, over the last eight years, HCSA workers have accounted for 62% of the nonfatal workplace violence injuries involving days away from work across all industries. With a rate of 9.0 per 10,000 full-time equivalents (FTEs), the risk of HCSA workers experiencing an assault that requires time off from work is 4.5 times greater than the overall workforce rate of 2.0 per 10,000 FTEs [2]. These numbers and rates represent only the assaults that resulted in time away from work and not the less severe physical injuries or the psychological trauma that HCSA workers experience from workplace violence.

Compounding the complexity of measuring workplace violence related injuries to HCSA workers is the issue of underreporting. The literature suggests that the number of assaults reported by healthcare workers is greatly underreported [3–7]. Some reasons for not reporting assaults are: lack of awareness; cumbersome reporting process; fear of reprisal; assaults not being intentional (e.g. dementia); persistent perception within the healthcare industry that workplace violence is ‘part of the job’; poor or non-existent institutional policies, procedures, staff training or support; concern that violence happens so frequently that it’s time-consuming to report every event; lack of response when reporting; and fear that reporting will reflect poorly on the worker (victim blaming) [8–11]

Preventing violence against healthcare workers is a complex issue because of the variation in purpose and design of healthcare facilities and the diverse duties performed by the numerous direct and indirect care occupations encompassed in the healthcare industry. Complicating the issue even more, as reported in the literature and through many conversations with healthcare workers over a period of time is the fact that the majority of healthcare professionals entering the profession have not received training in workplace violence prevention strategies [12–16]. Additionally, many of the experienced healthcare professionals have not received formal training in workplace violence prevention strategies [12].

Recognizing the need for a workplace violence prevention course that will benefit many occupations within healthcare, NIOSH researchers collaborated with a multi-disciplinary team consisting of a healthcare education grantee, healthcare workplace violence prevention experts from academia, labor, professional organizations, government agencies, and private consultants to develop an on-line course accessible through any device with an Internet connection. Designed to keep the interest of all healthcare workers, ranging from the novice healthcare worker to the most experienced, the interactive course employs text, case study videos, and personal interviews to convey the training materials using various approaches. The purpose of this paper is to describe the development, content and evaluation of the

online course, as well as future directions for application in various occupations within the HCSA sector.

2. Course development

NIOSH and the grantee researchers compiled recommendations for course material related to risk factors, prevention strategies, and incident response into an outline of potential course modules. An expert panel of healthcare violence prevention researchers then suggested content for the course and provided resources to substantiate their recommendations. Each expert had several opportunities to comment on all of the course content via email. Additionally, 90% of the experts participated in face-to-face full-day meetings annually, while the remaining 10% participated via conference call, during the first two years of the project. The course development process was enhanced through face-to-face meetings, which generated discussions regarding the course content and helped to facilitate establishment of the best methods for presenting the material in an on-line educational format. The recorded discussions were facilitated by the NIOSH project officers and the grantee project managers. Many minor changes were made in real-time during the meetings. NIOSH and the grantee researchers collaborated between the annual meetings to incorporate more substantial suggested changes into the course materials.

Smaller working groups of NIOSH and the grantee researchers and the experts with the most relevant research to specific topic areas provided additional input into the course content. These working groups also discussed ways to make the content interactive and stimulating for taking the course. The changes that were made by these working groups were sent via email to the entire team of researchers for input. The team input was evaluated by NIOSH and the grantee researchers that were serving as the project leads to determine how to design the course to incorporate the suggested material.

The number of units in the course expanded over the two-year development period. The project team decided that having several topic specific units was more effective than having just a few units that covered several topics under an umbrella approach. Each of the thirteen resulting course units (Table 1) were designed to take approximately 15 to 20 minutes to complete during a single session or over a longer period using the “resume-where-you-left-off” technology. Free continuing education credits are available after completing the course for those healthcare professionals that have such a licensing requirement.

3. Course content

The content of the course is a culmination of findings from academia, labor, nursing organizations, and government research. More specifically, Occupational Safety and Health Administration Guidelines, Veterans’ Health Administration Programs, and results from partners’ research were used to develop course content.

3.1. Nurse’s voices

The course contains introductions to most of the modules, which are entitled “Nurse’s voices”. These video comments by nurses serve as background for the content of each

module. The nurses in the videos discuss details about violent situations that they were involved in during their careers.

3.2. Definition, types, prevalence (Unit 1)

This unit serves as background for the entire course. It assists with raising awareness by starting with the NIOSH working definition of workplace violence – "*violent acts, including physical assaults and threats of assault, directed toward persons at work or on duty*" [17]. Violence is further defined by typology: Type I: Criminal Intent where the perpetrator does not have any reason to be in the place of business other than committing a crime, such as a robbery. Type II: Customer/client where the perpetrator of the violence is receiving a service from the victim. An example of Type II violence is a nurse tending to the medical needs of a patient when the patient strikes the nurse. Type III: Worker-on-worker where the perpetrator is a current or previous employee of the business, such as a worker threatening a co-worker with physical violence. Type IV: Intimate Partner Violence where a worker's intimate partner perpetrates an act of violence in the workplace, such as when an intimate partner shows up in the workplace to continue an argument that started in the home [18–20]. Customer/client and worker-on-worker violence are the most common in the healthcare industry, therefore the course has modules dedicated to these two types of violence [21,22]. Criminal Intent and Intimate Partner Violence were addressed in the course, but in much less detail.

3.3. Workplace violence consequences (Unit 2)

It is important for healthcare workers to understand that they are not the only healthcare worker affected personally and professionally by physical and verbal workplace violence. For many healthcare workers, negative outcomes attributed to workplace violence include: physical injury, low morale; decreased productivity; increased job stress; increased absenteeism; family issues, such as marital problems; and a negative view of the work environment [23–25]. One negative outcome associated with workplace violence, turnover, is illustrated by the results from a survey of registered nurses conducted by the American Nurses Association. Of the survey participants, 17% experienced physical assaults in the workplace during the last year and 57% were either threatened or verbally abused while working. The survey revealed that health and safety concerns such as workplace violence play a major role in nurses' decisions about whether to remain in the profession. In fact, one-fourth of the nurses responding to the survey expressed concerns about being assaulted in the workplace [26].

The psychological impact of workplace violence is not only an issue for the victim but also for any co-workers that witnessed the incident or for co-workers that hear about the incident after it happened [22,23, 25,27]. In some severe cases, a healthcare worker may go into crisis as the result of being a workplace violence victim or witness. Crisis is defined as *"an acute emotional upset; it is manifested in an inability to cope emotionally, cognitively, or behaviorally and to solve problems as usual"* [23].

Healthcare professionals suffering from any outcomes of workplace violence may not be able to perform to their normal standards of care, thus placing themselves and patients at

risk for injury or patient care error. The effects of these outcomes can vary from short-term to long-term in nature and may require professional counseling to recover completely [23–25,27, 28].

3.4. Risk factors for type 2 violence (workplace violence committed by patients/clients) (Unit 3)

Many factors contribute to healthcare workers risk of experiencing violence committed by a patient or client. Examining these factors from various perspectives may encourage healthcare workers to suggest prevention strategies for implementation in their facilities. Violence may occur anywhere in a hospital, but is most frequent in psychiatric units, emergency departments, waiting areas, and in geriatric/long-term care units [27,29–31]. Additionally, large numbers of nurses work outside the hospital in high-risk public sector healthcare settings such as prison and jail medical units, drug and alcohol residential treatment facilities, or as visiting nurses [15,21,32]. The degree to which each of these workplaces emphasizes worker safety varies widely. The risk factors for violence vary from hospital to hospital, and in home care settings, depending on location, size, and type of care.

Research demonstrates that patients perpetrate the majority of violence in the healthcare setting [21,23, 27]. Researchers use various methods of categorizing workplace violence risk factors. For purposes of the on-line course and as guided by the Occupational Safety and Health Administration (OSHA) “Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers,” risk factors for patient/client-on-worker violence are categorized into clinical (or, patient care), environmental, organizational, social, and economic [33].

From the clinical perspective, indicators that patients may be more likely to act out violently include being under the influence of drugs or alcohol; severe pain; history of violence; cognitive impairment (e.g. dementia); and certain psychiatric diagnoses (e.g. personality disorder) [22,34–37].

Environmental risk factors are unique to each facility because they relate to the physical layout, design, and contents of the workplace. However, environmental risk factors that all facilities must consider include unsecured access/egress into or throughout the facility; insufficient heating or cooling; irritating noise levels; unsecured items, such as furniture that can be used as weapons; and lack of personal security alarms that permit staff the ability to respond appropriately to workplace violence incidents [35,38].

Organizational risk factors are the policies, procedures, and prevailing culture of the organization related to safety and security. Policies and procedures involving security guards and their training in workplace violence prevention, incident reporting, staffing levels, shift duration, and overtime are the organizational risk factors that all facilities should consider when developing a comprehensive program [33,39]. Another factor to consider is management and staff attitudes toward workplace violence prevention, as well as commitment to safety [33].

Social and economic risk factors vary greatly in nature, but are viewed by most healthcare workers as an increasing problem [22,35]. OSHA states that examples of social risk factors include the prevalence of handguns and other weapons among patients and their visitors; the increasing use of healthcare facilities by authorities as criminal holds; and presence of gang members, drug or alcohol abusers, trauma patients, or distraught family members [33]. Challenging economic circumstances can contribute to risk factors on a personal level in the form of stress levels and on an organizational level in the form of short staffing (e.g. not enough staff on duty) [22,33,35].

3.5. Risk factors for type 3 violence (workplace violence committed by co-workers) (Unit 4)

Healthcare workers commonly face another type of violence on the job that is called horizontal violence or co-worker violence. The Joint Commission on Accreditation of Healthcare Organizations has acknowledged that “intimidating and disruptive behaviors” among co-workers in healthcare settings can adversely affect patient care and safety [28]. These behaviors include “verbal outbursts and physical threats as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities” [28]. The Joint Commission cited many root causes of co-worker violence including the unique culture of healthcare, which includes “… daily changes in shifts, rotations, and interdepartmental support staff”. All of these elements combined with the real or perceived continuously changing roles and responsibilities of healthcare professionals contribute to a difficult environment for effective communication and team building [28].

Disruptive behavior by co-workers, whether they are nurses, physicians, or other healthcare workers may go unreported because the healthcare worker feels their options for recourse are limited [28]. This is especially true when the target of the violence perceives the perpetrator as having more authority. When considering violence between co-workers it is important to distinguish between an incident of workplace violence and an isolated event that may be better described as a personality conflict. Although, worker-on-worker violence can be a one-time event, it frequently becomes an on-going and persistent verbal or electronic abuse of a co-worker. The best solution is to resolve any conflict before it becomes workplace violence [28].

3.6. Prevention Strategies for organizations (Unit 5)

Workplace violence prevention strategies for organizations involve policy, program, and practice. A good place for organizations to start their prevention efforts is OSHA’s (2004) workplace violence prevention guidelines. These guidelines outline five elements for an effective workplace violence prevention program: management commitment and employee involvement; worksite analysis; hazard prevention and control; safety and health training; and recordkeeping and program evaluation [33]. It is the responsibility of each organization’s administration and employees to apply these principles to the specific needs of the workplace. These are guidelines and are not enforceable by law. However, the Occupational Safety and Health Act of 1970 section 5(a)(1) the “General Duty Clause” requires employers to provide “…a place of employment free from recognized hazards that are causing or likely to cause death or serious physical harm to his employees.” Workplace

violence is a recognized hazard in the healthcare industry and may be cited by OSHA inspectors using the “General Duty Clause.”

3.7. Prevention strategies for nurses (Unit 6)

Employees are encouraged to become proactive in preventing workplace violence by volunteering to participate on workplace violence prevention committees, attending prevention training offered by the employer, becoming familiar with the workplace violence prevention programs and policies, and reporting all incidents including those witnessed [33].

Preventing violence perpetrated by patients involves knowing the risks present in specific areas within the workplace, such as room configuration, moveable furniture, and items suitable for use as weapons can assist the employee with developing a personal prevention plan [33]. High risk times of day, such as meal times, medication times, and shift changes should also be included in a personal prevention plan [29,33]. Maintaining an awareness of verbal and non-verbal behaviors exhibited by patients and their visitors in the immediate area is very important in preventing workplace violence. Most people provide warning signs prior to committing acts of workplace violence, such as verbally expressed anger and frustration and/or nonverbal threatening gestures [30,33].

Employees working in non-institutional settings, such as home healthcare providers, have additional risks associated with people in the patient’s home and high crime neighborhoods. A safety checklist completed prior to the first visit to the home is important for confirming that a background check (history of violence or crime, drug and alcohol abuse, mental health diagnoses) is completed on the patient and the patient’s family members [21,33]. Additional safety measures from the OSHA Guidelines include: being accompanied by a team member when a home situation is potentially dangerous; traveling with a cellphone; ensuring that employers know where field employees are; and using a code word to let the employer know of trouble [21,33].

No matter if the employee is in an institutional or non-institutional setting, reporting all workplace violence incidents is very important. Successful workplace violence prevention programs encourage reporting of all incidents, so they can be investigated to assist with prevention of similar incidents in the future [33]. The literature suggests that employees are more likely to report incidents when the process is simple and not time consuming [4,9].

The incident reports combined with records such as, workers’ compensation, safety reports, OSHA 300 injury logs (if required), insurance records, and police reports will assist the employer with identifying trends and high-risk conditions [33]. Analyzing these data can assist the employer with developing prevention and intervention strategies to ultimately reduce violence against workers and the physical and psychological outcomes [33,40].

3.8. Intervention strategies (Unit 7)

Crisis is the final stage along a continuum of behavioral and emotional responses. Employers and supervisors need to recognize when a patient, co-worker, or other individual is moving toward crisis, where they are along the crisis continuum, and apply interventions that de-escalate the individual’s response to stressful or traumatic events. There are four

stages in the crisis continuum each with interventions that are effective in reducing negative outcomes [23,41–44]. Stage 1 is normal stress and anxiety level and stage 2 is rising anxiety level. For stages 1 and 2, an employee's words and demeanor can defuse tensions, so be aware of their tone of voice, choice of words, and body language when responding to a person in crisis (patient, co-worker, or other individual). Stage 3 is severe stress and anxiety with the individual showing signs of loss of self-control and problem-solving ability. Verbal and non-verbal interventions are effective at this stage and the focus needs to turn to protecting oneself and those around you. Enlist the help of others (i.e. coworkers, security) and be prepared to use your panic device. Limit-setting techniques, such as restricting the person to a specific area, can be useful in this situation. Stage 4 is crisis with the individual being out of control. An individual in crisis is unresponsive to verbal intervention, cannot think clearly or appropriately, cannot express their needs and concerns, and displays fear, anger, and/or threats [23,41–44]. The employee needs to ensure their safety and the safety of others. If the situation escalates to a level that any form of restraint is necessary, then the employee must be careful to follow their organization's policies and procedures while using physical and/or chemical restraint to contain the individual.

3.9. Post event response (Unit 8)

The goal of crisis resolution is to prevent violence from occurring or escalating, to assist the individual's return to normal cognitive, emotional, and behavioral functioning and to avoid crisis recurrence [23,41–44]. When a violent incident occurs, the employee should file an incident report and report any physical or emotional injuries. They should also utilize their organization's support resources such as the Employee Assistance Program (EAP) to assist in their recovery.

The employer should assist the employee with the reporting process and filing workers' compensation claims. The employer should also make staffing reassignments that will keep the worker away from the perpetrator [33]. If the employer is required to file OSHA logs and the incident resulted in a qualifying injury to the employee, then they need to include the incident on the OSHA 300 injury log. It is good practice to evaluate the incident to see what procedures worked to contain the incident and to see what can be changed to prevent similar incidents in the future.

3.10. Case studies

The course provides reenactments of real life incidents as case studies. These case studies provide an opportunity for participants to see reactions during situations in different healthcare facility settings. Transcripts of these case studies with learning points highlighted are provided within the course content.

3.10.1. Case study 1 – Intervention with a psychiatric patient in an emergency department (Unit 9)—The aggressive patient in this case study was brought to the emergency department (ED) by the police. During the month prior to this incident, he was expelled from his college dorm due to aggressive behavior and substance abuse. He subsequently moved back into his parents' home. Immediately preceding today's ED visit, he put his fist through a wall and then turned his rage toward his father. His parents called

the police to bring him to the hospital for evaluation, because they suspect he has stopped taking his medication for bipolar disorder.

Upon arrival at the ED, the security officer performs a weapons check as routine practice when patients are presented by police, or if they have a record of past violence. The triage nurse noticed several signs that the patient may become violent again (i.e. disheveled appearance, agitation, pacing, fidgeting, and clenched fists). Examination of the patient's hospital records reveals a history of violent behavior. He was recently in the ED on two occasions, one for disruptive, violent behavior, and one for a drug overdose. He rated "high" for dangerousness on assessment from one of his previous ED visits.

The video re-enactment of this case study demonstrates several effective techniques for minimizing the chance of further violence from this patient. The security guard does not leave the patient alone with nursing staff. He escorts the patient to the triage nurse and down corridors from the ED to the psychiatric consulting office rather than releasing the patient to move through the hospital alone. The security officer and the nurses make every effort not to touch the patient as touching can be perceived negatively by the patient. As a consequence the patient could lose control despite his best efforts. Other calming techniques used by the security guard and the nurse are talking to the patient in a calm and caring manner and looking directly at the patient while not staring. The nurse inquired how the patient was feeling rather than telling him how he should feel. It is crucial to get the patient to feel responsible for his own care. By actively collaborating with the patient in his own care, he maintains his dignity and is personally empowered in taking next steps.

When the patient was brought to see the psychiatric nurse, the officer introduced the patient and stayed outside the door to give some privacy, but with clear sight lines and the ability to see the psychiatric nurse if help was needed. The room seemed free from any dangerous items or a configuration that could have put the nurse in harm's way. The nurse sat at a 45-degree angle from the patient, giving him his space; she was positioned so that the patient would not block her access to the door. She could have sat across the table from him or moved there if he had gotten more intimidating or put her at risk.

3.10.2. Case study 2 – Aggressive family member (Unit 10)—A post-partum patient recovering from a cesarean section is having her bandages changed by a nurse when her short-tempered husband enters the room. The nurse asks the husband to step into the hall for a few minutes while she finishes changing the bandages. He is offended with the request and becomes belligerent towards the nurse. His wife convinces him to step out of the room, but on his way out he shoves the nurse. The nurse is shaken by the incident and reports it to her supervisor. The supervisor encourages her to complete an incident report.

The nurse and her supervisor decide to meet with the patient's husband directly. They ask him to step into the supervisor's office in an attempt to protect his privacy. This is an appropriate course of action on the surface, but the nurse and her supervisor have now placed themselves in a room with the aggressive husband standing between them and the only exit. During their conversation with the husband they do recognize that he is anxious about his wife and baby. Acknowledging the person's concerns in an empathetic manner can

assist with de-escalation of tense situations. In this instance the husband apologizes for his actions and the matter is closed.

3.10.3. Case study 3 – Homicidal home care patient (Unit 11)—A home health nurse has provided in-home child-care counseling and supervision for six months to a mother and her infant (born preterm). Upon her assignment to this case, the nurse's agency performed a pre-home visit assessment. The assessment determined that, although the neighborhood was somewhat depressed, there was no imminent threat to the nurse. Budget constraints necessitated that the nurse make the visits alone. Over the course of these weekly home visits, the nurse and mother developed a trusting relationship.

Shortly before the nurse began counseling the mother, the mother's 4-year-old son was placed in his grandmother's custody. This was the result of a social services investigation into child abuse and drug use in the home. The mother confided to the nurse that she had taken the blame for her boyfriend's abuse of her child hoping to spare him from going back to jail. He went to prison anyway on a drug charge, and the mother lost custody of her son. During the nurse's most recent visit, the mother's mood darkened and her conversation turned threatening as she told the nurse about her plans for retaliating against the social worker by stabbing her. The mother is convinced that she can get away with this plot and tells the nurse that nobody else knows about this plan. She then states that if the police come after her then she will know that the nurse told them and she will kill her.

After safely extricating herself from the house and reporting the incident to her employer, the nurse finds that she is still quite shaken. As an employee benefit, her employer offers a confidential Employee Assistance Program (EAP) as an option. Though she is under no obligation to seek counseling or use a company-provided counselor, she decides to take the opportunity to use EAP to help her deal with the incident.

She tells the counselor that she had developed a good rapport with her client, which may have contributed to her losing sight of the reality that this was a troubled family household. She believes this is why she was unprepared when the violence spilled over to include her. When she was confronted with the threat of violence, she remembered her training that told her that if the threat is not immediate (e.g. threat was based on future events) to remain calm and remove oneself from the situation as quickly as possible. After leaving the house the nurse called the social worker to warn her of the possible danger. The social worker and her employer made plans to include other people in her future visits with the mother.

3.10.4. Case study 4 – Injuries from the cognitively impaired (Unit 12)—A licensed practical nurse (LPN) and a certified nursing assistant (CNA) working in a long-term care facility are verbally and physically abused by a cognitively impaired (Alzheimer's disease) resident. The patient has been striking out at nursing staff with verbal insults and personal threats as well as physical attacks including slapping, punching, and kicking. At a loss for solutions to this problem, the LPN and CNA approached their nurse manager with their concerns.

The nurse manager was concerned and went to speak to the patient directly. The nurse manager explained her position as the manager and about her concerns regarding the patient striking out at the nursing staff. He was polite enough, but he said he couldn't remember ever hitting or yelling at any of the nurses and said he really liked everyone here. The nurse manager then consulted with the patient's physicians and with the pharmacist at the facility. Together they ruled out any possible medical reasons for his behavior, any medication interactions, infections, or pain. She checked with his family to see if there's anything that might trigger this kind of behavior. They didn't have any suggestions to offer. So, to ease the burden on the nursing staff the nurse manager set up a two week rotation schedule to spread the stress out a bit. But instead of making things better, things got worse. That is when she decided to call a consulting clinical nurse specialist in gerontological psychiatry to discuss other courses of action.

Together they decided to create an interdisciplinary team to identify patterns of behavior in both the patient and his caregivers. Knowing that certain behaviors by staff may trigger abusive behaviors in the patient at certain times but not at others, the team decided to examine the entire picture rather than just the abusive moments. This exercise was designed to help the team isolate the environmental factors from the behavioral factors.

The consulting nurse started her evaluation by examining incident logs. When she was partially through the incident reports the LPN and CNA entered the room speaking to each other in Spanish. The consulting nurse asked if they speak Spanish in front of the patients on a regular basis. They admitted that they do frequently. The consulting nurse had just reviewed an incident report that had an entry where the patient became agitated and yelled at the LPN and CNA to quit talking about him. Speaking in another language in front of a patient with a cognitive disorder may sometimes add to their confusion. The consulting nurse suggested that the staff try speaking only English when the patient is present and see if that helps.

While analyzing the incident reports she noticed that most of the incidents occurred when the staff members were trying to keep all the patients on a schedule, such as at transition times before meals. She suggested making the scheduling a little less rigid and less structured for the patients. It is important to remember that the normal aging process can add to feelings of frustration, anxiety, sadness, confusion, and anger. For some residents, living in a long-term care facility can be frustrating, for example the routines around meals, bathing, and sleep hours can be irritating. Others will experience a deep sense of loss and loneliness as a result of moving from their home and family. Simple environmental conditions, such as changes in noise levels, odors, and lighting can be upsetting to some residents.

The care team should begin with an assessment of the resident to identify the aging processes that may be contributing to frustration and thus aggressive behavior. Data collection, including learning from a resident's family and medical team, is also crucial to determine behavior patterns. The key to a successful plan of care is that it needs to be designed for the individual.

3.10.5. Case study 5 – Patient's inappropriate sexual behavior (Unit 13)—A frustrated patient expresses anger at a certified nursing assistant (CNA). The patient's physical injuries restrict his movements but those restrictions also lead to his heightened feelings of frustration and aggravation, both early warning signs of possible violence. The patient follows the verbal outburst with a sexual advance that involved him grabbing the CNA's posterior. The nursing assistant responded by telling the patient that his actions were inappropriate and she left the room. She immediately reported the incident to her supervisor.

She told her supervisor that the patient has been demanding and impatient, yelling at several staff members that they were not moving fast enough. She further explained to the supervisor that this time he really crossed the line, making remarks about her body, and then grabbing her posterior. She insisted that she not be assigned to his room anymore.

The charge nurse decided to speak with him about the incident and to reassign the CNA so she would not have to interact with him for the remainder of his stay. The charge nurse said she was taking the matter seriously and that she was filing an incident report. The charge nurse's actions demonstrate support for the staff member.

The charge nurse initiates her conversation with the patient by telling him that she remembers when he was admitted and she wanted to check to see how he is doing. He states that he is frustrated with his condition that requires him to stay in the facility. She reminds him that he is making good progress in his recovery. She then changes the conversation to a discussion of the incident that the CNA reported to her.

The patient did not realize that his behavior was problematic. He said he was acting out because he rings his nurse button and people do not respond immediately. The charge nurse explained that the staff members take care of more than one patient and they are often already attending to another patient when he presses his call button. She explained that he cannot receive the care that he needs if he is taking out his anger and frustration on the nursing staff. She then asked about the incident where he grabbed the nursing assistant. He stated he was just being friendly. The charge nurse explained in a calm and nonthreatening manner that it was not a friendly gesture, but an unwelcomed sexual advance.

To keep the therapeutic relationship intact, a nurse may need to set limits on behavior if inappropriate behavior is exhibited. Many nurses ignore the inappropriate behavior but in doing so they unknowingly perpetuate it. In this scenario, the CNA reacted to the unwelcome sexual advance by letting the patient know his actions were inappropriate and unacceptable. She stated clearly to the harassing patient that his actions should not be repeated and were clearly unwelcome. She had completed the patient's request, so promptly left the room. Rather than ignore the issue, the CNA rightly reported the incident to her supervisor.

4. Course focus group evaluation

Staff members of the grantee conducted a focus group with nine nurses from a variety of specialties and different healthcare facilities in the Boston, MA area. Each of these nurses completed the on-line workplace violence prevention course prior to participating in the

focus group. Focus group participants discussed the course format, course technology, ease of use, content, and suggestions for improvements. Overall, the course received positive reviews with most of the comments addressing course navigation issues, such as consistency of button placement and menus to allow navigation from page to page or unit to unit. All technical issues discussed by the focus group were addressed by the course development team.

The focus group participants indicated that the course content touched on all types of violence that nurses encounter, including nurse-on-nurse violence. Some participants requested that future versions address doctor-on-nurse violence, nurse-on-doctor violence, and bullying of new nurses by nurses with seniority. The suggestions for additional course content are being considered for future course revisions. The content of the course was viewed to be at an appropriate learning level for novice and senior nurses.

Comments about the case studies included issues such as, optional endings to show how to handle the situations when everything is handled correctly but things still escalate out of control. The case studies in their current format present actual cases with real outcomes, but many of the participants considered these cases to be the ideal situation where everything went fine. The facilitator explained that this is by design to incorporate comments by experts about why these situations proceeded without incident and what may have resulted in a different outcome. The focus group participants then indicated that this is an acceptable format, but suggested the case studies place more emphasis on the learning points.

The case study about the patient suffering from dementia made many of the participants look differently at reporting such incidents. One participant stated that, “Nurses do not typically file incident reports for patients with dementia.” However, after viewing the case study that individual said, “they now understand how reporting may help prevent future events.”

Focus group participants suggested that the course could be incorporated into training within a healthcare facility as a lunch and learn (brown bag lunch) with continuing education units offered. To accomplish this, the course needs to include a set of slides with handouts for discussion at the lunch. Offering the course as a self-paced orientation training was viewed as a potentially effective way to present workplace violence information to new employees.

Participants suggested that NIOSH consider collaborating with nursing schools to make the course part of their curriculum. If NIOSH pursues this option, then some suggested that a module about nurses with seniority bullying recently hired nurses be an additional module for the course. Participants stated that the ideal time to require this course in the curriculum is during the junior or senior years when the students are doing their clinical work.

5. Future directions

Future evaluation of the course will include a formal evaluation of the on-line training program with approximately 200 nurses from across the United States. Each nurse will take a pre-and post-course survey that asks questions regarding knowledge of what constitutes workplace violence, their attitudes towards violence, perceptions of the magnitude of

violence, and behavioral intentions of those committing violent acts. The post test will be given immediately after completion of the training and again four weeks later. This evaluation will provide data regarding the potential impact that an on-line training course can have in prevention of workplace violence.

Further development of the course will include occupation specific modules. Occupations being considered currently include those in emergency departments, psychiatric units, nursing homes, social services, home healthcare, emergency responders, and independent physicians' offices. The intent is to make each of these modules approximately one-hour in duration and award one hour of continuing education for completion of each occupation specific module. The course was developed to incorporate continuous updating in areas that change periodically, i.e. workplace violence statistics and other occupation specific modules.

The course is available for free at http://www.cdc.gov/niosh/topics/violence/training_nurses.html.

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Table 1

Course contents by unit title
1. Definitions, Types, Prevalence
2. Workplace Violence Consequences
3. Risk Factors for Type 2 Violence
4. Risk Factors for Type 3 Violence
5. Prevention Strategies for Organizations
6. Prevention Strategies for Nurses
7. Intervention Strategies
8. Post-Event Response
9. Case Study 1 – Psychiatric Patient in ED
10. Case Study 2 – Aggressive Visitor
11. Case Study 3 – Home Care Threat
12. Case Study 4 – Injury from Cognitively
13. Case Study 5 – Sexual Advance
14. Course Evaluation Impaired Patient